Independent Resolutions Inc.

An Independent Review Organization

Phone Number: **(682) 238-4977**

835 E Lamar Blvd. 394
Arlington, TX 76011

Fax Number: **(817) 385-9610**

Email:independentresolutions@irosolutions.com

Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Arthroscopic Acromioplasty, AC joint debridement of the left shoulder

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who reported an injury to his left shoulder on xx/xx/xx when he was lifting resulting in a sharp pain at the left shoulder. The clinical note dated xxxx indicates the patient complaining of 2/10 2-8/10 pain at the left shoulder. The note indicates the patient is utilizing ibuprofen for pain relief. Upon exam 3/5 strength was identified with flexion and extension at the left shoulder. Tenderness was identified at the bicipital groove and the supraspinatus muscle. Therapy note dated xxx indicates the patient having completed four physical therapy sessions to date. The clinical note dated xxxx indicates the patient complaining of ongoing left shoulder pain. The note indicates the patient having a positive impingement sign at the left shoulder. Range of motion deficits were identified specifically with abduction and flexion secondary to pain. There is indication the patient had undergone x-rays which revealed essentially normal findings. The MRI of the left shoulder dated xxxx revealed no high grade or full thickness rotator cuff tear. A moderate supraspinatus contusion/tendinosis was identified with bursal surface fraying. Mild infraspinatus tendinosis was also identified with bursal surface fraying. A lateral downsloping type 2 acromion was identified. The patient was identified as having positive impingement findings. The clinical note dated xxxx indicates the patient having return to work at light duty. There is indication the patient had temporary relief with a subacromial injection at that time. The note indicates the patient complaining of pain with abduction from 90-120 degrees. Strength deficits were identified with abduction and forward flexion. The clinical note dated xxxx indicates the patient recommended for a surgical intervention at the left shoulder. The utilization reviews dated xxxx and xxxx resulted in denials as insufficient information had been submitted regarding the patient's completion of all conservative treatment.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The clinical documentation indicates the patient pay of left shoulder pain associated range of motion deficits. There is an indication the patient has bursal surface fraying at the supraspinatus and infraspinatus confirmed by imaging studies. Additionally, there is an indication the patient has positive clinical findings. However, an acromioplasty is indicated for patients who have completed a full three month course of conservative therapy. There is indication the patient completed four physical therapy sessions a day. However, no information was submitted regarding the patient's completion of a full three month course of treatment. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for an arthroscopic acromioplasty with acromioclavicular joint debridement of the left shoulder is not

recommended as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)